

Federal Communications Commission

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**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

In the Matter of

Changes to the Board of Directors of the National Exchange Carrier Association, Inc.

Federal-State Joint Board on
Universal Service

CC Docket No. 97-21

CC Docket No. 96-45

SIXTH ORDER ON RECONSIDERATION in CC Docket No. 97-21
FIFTEENTH ORDER ON RECONSIDERATION in CC Docket No. 96-45

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I. INTRODUCTION

1. In this *Fifteenth Order on Reconsideration*, we reconsider, on our own motion,¹ some of the Commission's conclusions in the *Universal Service Order*² in order to simplify the process for rural health care providers to receive support from the universal service support mechanism. Specifically, we amend our rules to permit the Universal Service Administrative Company (USAC) to provide support for any commercially available telecommunications service, regardless of the bandwidth. We further modify our rules to require USAC to calculate support based upon all actual distance-based charges, unless the rural health care provider or carrier requests a more comprehensive support calculation and substantiates that request. We affirm the conclusion reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to significant abuse of the prohibition on resale. Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support, and we clarify our use of the term "tariffed or market rate" to permit a rural health care provider participating in a consortium with ineligible private sector members to receive support. Finally, in order to achieve a more equitable distribution of USAC's joint and common billing and collection costs, we clarify that USAC should include these costs in the projected administrative expenses of the high-cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program.

II. BACKGROUND

2. In the Telecommunications Act of 1996 (1996 Act),³ Congress sought to provide rural Americans with affordable access to quality health care by giving rural health care providers the opportunity to obtain telecommunications services at urban rates. To accomplish

¹ In light of pending petitions for reconsideration in this proceeding, the Commission retains jurisdiction to reconsider its own rules on its own motion. See 47 U.S.C. § 405, 47 C.F.R. § 1.108; see also *Central Florida Enterprises, Inc. v. FCC* 598 F.2d 37, 48 n.51 (D.C. Cir. 1978), cert. dismissed, 441 U.S. 957 (1979).

² *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997), as corrected by *Federal-State Joint Board on Universal Service, Errata*, CC Docket No. 96-45, FCC 97-157 (rel. June 4, 1997), affirmed, reversed, and remanded in part sub nom. *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393 (5th Cir. 1999) motion for stay granted in part (Sept. 28, 1999), petitions for rehearing and rehearing en banc denied (Sept. 28, 1999) (*Universal Service Order*).

³ Pub. L. No. 104-104, 110 Stat. 56 (1996 Act).

this goal, Congress added new section 254 to the Communications Act of 1934 (the Act).⁴ Section 254 directs telecommunications carriers to provide telecommunications services, to any rural public or non-profit health care provider, at rates that are reasonably comparable to rates charged for similar services in urban areas in the same state.⁵ The Act further requires that universal service support mechanisms should be specific, predictable, and sufficient.⁶

3. Section 254 requires the Commission to institute and refer to a Federal-State Joint Board (Joint Board) under section 410(c), a proceeding to recommend changes to any of its regulations in order to implement section 254.⁷ Accordingly, on March 8, 1996, the Commission adopted a *Notice of Proposed Rulemaking* in which it sought comment on ways in which to implement section 254 and referred the proceeding to the Joint Board.⁸

4. On June 12, 1996, the Commission established the Advisory Committee on Telecommunications and Health Care (Advisory Committee) to advise the Commission and the Joint Board on telemedicine.⁹ The Advisory Committee, which was made up of thirty eight individuals with expertise and experience in the fields of health care, telecommunications and telemedicine, issued its report on October 15, 1996.¹⁰

5. On November 7, 1996, the Federal-State Joint Board adopted its *First Recommended Decision* regarding universal service.¹¹ In the *First Recommended Decision* the Joint Board made numerous recommendations on universal service issues including rural health

⁴ 47 U.S.C. §§ 151 *et seq.* (Act). (Hereinafter, all citations to the 1996 Act and the Act will be to the Act as it is codified in the United States Code.)

⁵ 47 U.S.C. § 254(h)(1)(A).

⁶ 47 U.S.C. § 254(d); *see also* 47 U.S.C. § 254(b)(5).

⁷ 47 U.S.C. § 254(a)(1).

⁸ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, NPRM and Order Establishing Joint Board, 11 FCC Rcd. 18092, (1996) (*Joint Board NPRM*).

⁹ *Universal Service Order*, 12 FCC Rcd at 9094, n.1556.

¹⁰ FCC Advisory Committee on Telecommunications and Health Care, Findings and Recommendations (October 15, 1996) (Advisory Committee Report).

¹¹ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87 (1996) (*First Recommended Decision*).

care.¹²

6. On May 8, 1997, the Commission adopted the *Universal Service Order* beginning the implementation of section 254. The Commission concluded that any telecommunications service of a bandwidth capacity up to and including 1.544 Megabits per second (Mbps) that is necessary for the provision of health care services is eligible for support. Moreover, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account. The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider. Based upon generous estimates of the number of potentially eligible rural health care providers, and their service needs, and in an effort to establish support mechanisms that are specific, predictable, and sufficient, the Commission adopted an annual cap of \$400 million for universal service support for health care providers pursuant to sections 254(h)(1)(A) and 254(h)(2) of the Act.¹³ The Commission subsequently limited the support for the first funding cycle to \$100 million.¹⁴ The Commission appointed the Universal Service Administrative Company (USAC) to administer the program.¹⁵

7. In the first application period,¹⁶ the Rural Health Care Division (RHCD) of USAC

¹² *Id.*

¹³ *Universal Service Order*, 12 FCC Rcd at 9141, para. 705.

¹⁴ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Reconsideration and Fourth Report and Order in CC Docket No. 96-45, 13 FCC Rcd 14915, 14928-14933 (1998) (*Fifth Order on Reconsideration*).

¹⁵ *Changes to the Board of Directors of the National Exchange Carrier Association, Inc. and Federal-State Joint Board on Universal Service*, Second Report and Order and Second Order on Reconsideration, CC Docket No. 97-21 and 96-45, 12 FCC Rcd 18400 (1997) (*NECA Order*). In the *USAC Reorganization Order* released on November 20, 1998, the Commission directed USAC to assume responsibility for the schools and libraries support mechanism and the rural health care support mechanism effective January 1, 1999. See *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 96-45, 97-21, Third Report and Order and Fourth Order on Reconsideration, and Eighth Order on Reconsideration, 13 FCC Rcd 25058 (1998) (*USAC Reorganization Order*). The Schools and Libraries Corporation (SLC) and the Rural Health Care Corporation (RHCC) previously administered these programs, respectively, which have since been merged into USAC in accordance with the *USAC Reorganization Order*. *Id.*

¹⁶ The first funding cycle for the rural health care support mechanism covered the period from January 1, 1998 through June 30, 1999. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Ninth Order on Reconsideration, FCC 98-346, (rel. Dec. 31, 1998) (*Ninth Order on Reconsideration*).

received approximately 2,500 initial applications from health care providers throughout the nation.¹⁷ Yet only a small fraction of these applicants completed the application process and established their eligibility for the discounts.¹⁸ RHCD estimated that no more than \$2 million would be committed to the support of rural health care providers for the first funding cycle.¹⁹ Consequently, the Commission instructed USAC to: (1) evaluate ways to improve opportunities for eligible rural health care providers to take advantage of the support mechanism; (2) carefully review all of the administrative expenses associated with the rural health care mechanism, and determine where reductions can be made, so that the expenses are commensurate with the size of the support mechanism; and (3) evaluate anticipated demand for 1999.²⁰

8. On March 5, 1999 USAC, submitted a report with several recommendations for improving the rural health care program and for reducing administrative expenses.²¹ USAC also

¹⁷ See First Quarter 1999 Projected Demand and Expenses for the Rural Health Care Universal Service Support Program (filed Oct. 30, 1998). See also Universal Service Administrative Company Report to the FCC: Evaluation of the Rural Health Care Program at 40 (filed March 5, 1999) (USAC Report).

¹⁸ USAC Report at 40. In order for a rural health care provider to receive telecommunications services at urban rates, the rural health care provider must submit a total of four forms to RHCD. USAC Report at 11-12.

(1) FCC Form 465. This is the first form that the rural health care provider must complete. It communicates the rural health care provider's interest in receiving support for telecommunications service for a new or existing telemedicine program. RHCD uses the FCC Form 465 to determine the eligibility of the rural health care provider and to solicit competitive bids for the service. 47 C.F.R. § 54.603.

(2) FCC Form 466. After the description of the service has been posted on RHCD's Internet web site for 28 days, the rural health care provider may select a carrier. The rural health care provider uses the FCC Form 466 to notify RHCD of the carrier selected.

(3) FCC Form 468. The rural health care provider must forward a FCC Form 468 to RHCD at the same time that it submits the FCC Form 466. The carrier must complete the FCC Form 468. It is used to verify the services offered and to calculate the urban/rural rate differential.

(4) FCC Form 467. A rural health care provider must submit the FCC Form 467 to RHCD after the rural health care provider begins receiving the supported services. FCC Form 467 verifies that the rural health care provider received supported services from the carrier.

¹⁹ Letter from Lee E. Bailey, RHCC, to Kathryn Brown, FCC, dated October 28, 1998 (RHCC letter).

²⁰ *Federal-State Joint Board on Universal Service, Proposed First Quarter 1999 Universal Service Contribution Factors and Proposed Actions*, CC Docket No. 96-45, Public Notice, FCC 98-318 (rel. Dec. 4, 1998).

²¹ USAC Report at 2.

provided additional information on anticipated demand.²² On March 17, 1999, the Commission released a public notice seeking comments on the report.²³ We received eight comments and one reply comment.²⁴

9. A number of the issues highlighted in the USAC Report have been, or are being, addressed elsewhere.²⁵ In this *Fifteenth Order on Reconsideration*, we reconsider, on our own motion, several of our prior conclusions with respect to the rural health care program, as highlighted by USAC and others. As a result, we clarify or make further findings to accomplish the following:

- eliminate the per-location funding limit;
- affirm that the rural health care mechanism will not provide additional support for long distance service;
- simplify the urban/rural rate calculation;
- affirm that the rural health care mechanism will not provide support for equipment;
- encourage participation in consortia;
- clarify that the definition of "health care provider" does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities; and
- re-allocate billing and collection expenses of the universal service support mechanisms by program size.

²² *Id.*

²³ *Federal-State Joint Board on Universal Service, Universal Service Administrative Company Report to the FCC: Evaluation of the Rural Health Care Program, Pleading Cycle Established*, CC Docket Nos. 96-45 and 97-21, Public Notice, DA 99-521 (rel. March 17, 1999) (*USAC Report Public Notice*).

²⁴ See Appendix B for a list of commenters.

²⁵ On August 5, 1999, the Commission adopted a Further Notice of Proposed Rulemaking to address the unique issues that may limit telecommunications deployment and subscribership on tribal lands and in insular areas. *Federal-State Joint Board on Universal Service, Promoting Deployment and Subscribership in Unserved, Tribal, and Insular Areas*, CC Docket No. 96-45, Further Notice of Proposed Rule, FCC 99-204 (rel. Sept. 3, 1999) (*Unserved, Tribal, and Insular Areas FNPRM*). On September 21, 1999, the Commission adopted the *Fourteenth Reconsideration Order*, in which the Commission determined that all telecommunications carriers that provide supported services to eligible health care providers under section 254(h)(1)(A), are entitled to have a credit against their universal service contribution obligation equal to the difference between the lower, urban rate they offer eligible health care providers for supported telecommunications services and the higher, rural rates that would normally be charged to these customers. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, *Fourteenth Order On Reconsideration*, FCC 99-256 (adopted Sept. 21, 1999) (*Fourteenth Reconsideration Order*).

As a result of these modifications, we expect to improve opportunities for eligible rural health care providers to benefit from the support mechanism, and to reduce the administrative expenses associated with the mechanism. We are also hopeful that these changes will encourage more rural health care providers to participate in the rural health care program.

III. SCOPE OF SERVICES ELIGIBLE FOR SUPPORT

A. Per-Location Funding Limit

1. Background

10. The types of services eligible for universal service support limit the benefits available to rural health care providers. Section 254(c) gives the Commission and the Joint Board the responsibility for defining a group of core services eligible for federal universal service support.²⁶ Section 254(c)(3) also provides that, in addition to the "core" services described under the provisions of section 254(c)(1), the Commission "may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)." Section 254(h)(1)(A) states:

Health care providers for rural areas.--A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.²⁷

11. On October 15, 1996, the Advisory Committee issued a report that, among other things, recommended that the Commission limit universal service support to services of bandwidths up to and including 1.544 Mbps²⁸ or its equivalent.²⁹ The Advisory Committee explained that this is the minimum bandwidth necessary to allow eligible rural health care providers to access the basic set of telecommunications applications necessary for health care in

²⁶ 47 U.S.C. § 254(c)(1).

²⁷ 47 U.S.C. § 254(h)(1)(A).

²⁸ 1.544 Mbps is a digital rate of data transmission of 1,544,000 bits per second.

²⁹ Advisory Committee Report at 1-2.

rural areas.³⁰ The Advisory Committee developed a "market basket" of telemedicine services as a guide to estimate what level of telecommunications services would be necessary to support rural telemedicine.³¹ The Advisory Committee stressed that the minimum package should not be limited to telemedicine applications in the "market basket."³² According to the Advisory Committee, "[t]he eligible health care provider should be able to use the telecommunications services in the minimum package for any telemedicine applications the health care provider determines necessary."³³ The Advisory Committee noted that "this is especially important since needed applications in rural areas may differ from those needed in urban areas."³⁴ The Advisory Committee believed that "prices of services, even at discounted rates, will serve to self-monitor use of discounted services."³⁵ Accordingly, the Advisory Committee recommended that rural health care providers be given support for any telecommunications services that they choose within bandwidths up to and including 1.544 Mbps.³⁶

12. The Joint Board recommended support for telecommunications services, and made no recommendation as to the exact scope of services to be supported.³⁷ Instead, the Joint Board recommended seeking further information on this topic.³⁸ Consistent with the Joint Board's recommendation, the Commission issued a *Recommended Decision Public Notice* seeking information about the exact scope of services that should be included in the definition of services "necessary for the provision of health care in a State."³⁹ The Commission also requested

³⁰ *Id.*

³¹ *Id.* at 6. The "market basket" included the following telemedicine applications: (1) health care provider to health care provider consultation; (2) health care provider to patient consultation; (3) continuing medical education; (4) access to the most current medical information through the Internet; (5) support from on-call physicians and specialists at urban centers or at local physician offices; (6) transmission of high speed data and high quality images to urban medical centers for specialty services; and (7) interaction with health care providers at the site of emergencies. *Id.*

³² *Id.* at 7.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *First Recommended Decision*, 12 FCC Rcd at 421, para. 656.

³⁸ *Id.*

³⁹ *Federal-State Joint Board on Universal Service, FCC Common Carrier Bureau Public Notice Seeking*

input on the relative costs and benefits of supporting technologies and services that require bandwidths higher than 1.544 Mbps.⁴⁰

13. Based upon the recommendations of the Advisory Committee and the majority of commenters, the Commission found that higher bandwidth services were not necessary for the provision of health care services in a state.⁴¹ The Commission also found that the record "indicates vastly higher costs implicated in supporting services that employ bandwidths higher than 1.544 Mbps."⁴² The Commission noted:

We are mindful of the need to balance the needs of persons residing in rural areas of the state for telecommunications services necessary for the provision of health care with the costs of such services. This need for balance, coupled with most commenters' assertions that services with bandwidth greater than 1.544 Mbps are presently unnecessary for the provision of health care leads us to conclude that the cost of supporting such higher bandwidth services greatly exceeds the potential benefits of supporting such services at this time.⁴³

Accordingly, the Commission concluded that rural health care providers would be eligible to receive support only for telecommunications service employing a transmission speed up to 1.544 Mbps (T-1).⁴⁴ The Commission further concluded that "telecommunications carriers should not determine what telecommunications services health care providers should use or which should be eligible for support, because we believe that health care providers are best able to determine what telecommunications best meet their needs and are within their budgets."⁴⁵

14. Section 54.613 of the Commission's rules provides that each rural health care provider is limited to one supported T-1 connection.⁴⁶ A rural health care provider may purchase

Comment on Universal Service Recommended Decision, CC Docket No. 96-45, Public Notice, DA 96-1891 (rel. Nov. 18, 1996).

⁴⁰ *Id.* at 2.

⁴¹ *Universal Service Order*, 12 FCC Rcd at 9103, para. 622.

⁴² *Id.*

⁴³ *Id.* (citations omitted).

⁴⁴ *Id.*

⁴⁵ *Universal Service Order*, 12 FCC Rcd at 9103, para. 622 (citations omitted).

⁴⁶ 47 C.F.R. § 54.613.

more than one T-1 connection, but only one, within the Commission's distance limitation, would be supported by universal service funds.⁴⁷ If a rural health care provider chooses to subscribe to service with a lesser bandwidth, it may purchase more than one connection subject to universal service support, but the total annual support for these connections may not exceed the annual amount of support that would be available for one T-1 connection.⁴⁸ This amount, equal to the annual support for one T-1 connection, constitutes the maximum annual support amount or the "per location funding limit" (PLFL).⁴⁹ Eligible services with a lesser bandwidth include Frame Relay, Private Line Transport, ISDN, satellite communications, unlicensed spread spectrum, non-consumer point-to-point, and similar services.⁵⁰

15. USAC reports that this limitation on eligible services has severely limited the benefits available to rural health care providers in the program.⁵¹ Specifically, USAC notes that the rural health care providers indicate that:

While a number of services are included in the Program such as plain old telephone service (POTS), ISDN, Frame Relay, T-1, 56k, Centrex, and toll charges for Internet service providers, actual support is limited to the portions of those services with a mileage component which is provided by the ETCs.⁵² RHCD staff has found that POTS rates are generally the same in rural and urban areas and consequently are not eligible for support under this Program. Support for ISDN, Frame Relay, and Centrex is limited to the mileage-based link

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Universal Service Order*, 12 FCC Rcd at 9104, para. 624.

⁵¹ USAC Report at 36.

⁵² ETC is an acronym for eligible telecommunications carrier. Section 214(e)(1)(A) requires an ETC to "offer the services that are supported by Federal universal service support mechanisms under section 254(c)." 47 U.S.C. § 214(e)(1)(A). Pursuant to section 254(c), the Commission, based on the recommendation of the Federal-State Joint Board, determined that the following services or functionalities will be supported by universal service mechanisms: voice-grade access to the public switched network; local usage; dual tone multi-frequency signaling; single-party service; access to emergency services; access to operator services; access to interexchange service; access to directory assistance; and toll limitation for qualifying low-income customers. *See* 47 C.F.R. § 54.101(a)(1)-(9). Accordingly, in order to be designated as an ETC, a carrier must offer each of these services or functionalities.

extension. In the case of Internet service providers, service is generally provided on a toll-free basis, so actual support is minimal.⁵³

16. Further, USAC has discovered that, in some cases, although there may be no difference between the urban and rural rates for a T-1, there is a difference between the urban and rural rates for certain services with a lesser bandwidth.⁵⁴ A survey conducted by the Rural Policy Research Institute (RUPRI) confirms that few rural health care providers participated in the rural health care program because of the per-location funding limit.⁵⁵

2. Discussion

17. We eliminate the per-location funding limit because it has made it more difficult for rural health care providers to receive the benefits of the rural health care support mechanism, and it is no longer necessary to ensure that demand for support remains below the \$400 million per year cap that the Commission established in the *Universal Service Order*. We believe that eliminating the per-location funding limit will make it easier for rural health care providers to select and receive support for the telecommunications services that they need for telemedicine. We find that, even if USAC substantially underestimated the demand for support by rural health care providers, demand would still be well within the \$400 million cap. Moreover, we find that the Commission's initial decision to limit support to a T-1 or some combination of lesser services was driven by two express concerns that are no longer relevant.⁵⁶ We further find that, because the per-location funding limit imposes some cost and generates no apparent benefit, it would be contrary to the public interest to maintain it. Accordingly, we conclude that the universal service support mechanism for rural health care providers shall support any commercially available telecommunications services, necessary for the provision of health care services in a state, regardless of the bandwidth, and we revise section 54.613 of the Commission's rules to reflect this change.

18. Based upon the information in the record, we find that the Commission's initial demand estimate was much too high. Section 254(g) directs that universal service support mechanisms should be specific, predictable, and sufficient.⁵⁷ The only qualification, in section 254(h)(1)(A), of the type of telecommunications service that may be supported is the requirement

⁵³ USAC Report at 36.

⁵⁴ *Id.* at 21.

⁵⁵ RUPRI comments at 2.

⁵⁶ *See Universal Service Order*, 12 FCC Rcd at 9104, para. 623.

⁵⁷ 47 U.S.C. § 254(g).

that the telecommunications service be "necessary for the provision of health care services in a [s]tate."⁵⁸ In order to establish a "specific, predictable, and sufficient" mechanism for a program with no track record, the Commission concluded that it must limit the telecommunications services that a rural health care provider may receive for the provision of health care services in a state.

19. The Commission's original estimate for the cost of the program predicted that maximum demand for support would be \$366 million per year.⁵⁹ The Commission arrived at this conclusion without the benefit of expert assessment of the cost of leaving rural health care providers free to purchase whatever telecommunications services they deemed necessary for the provision of health care.⁶⁰ According to the USAC Report, "[t]he best current estimates show that this Program is not likely to exceed \$10 million in annual support level in the near term."⁶¹ Specifically, the USAC Report estimates that the total demand for support for rural health care providers will not exceed \$3.1 million for the 18 month period from January 1, 1998 through June 30, 1999.⁶² USAC projects that the total demand for rural health care provider support for the second funding year (July 1, 1999 through June 30, 2000) will be no more than \$9.3 million.⁶³ Although armed with a significantly more comprehensive set of data than used in the *Universal Service Order*, USAC estimates that, even if we remove the per-location funding limit, demand would not exceed \$10 million per year. Apparently, as the Advisory Committee believed, the urban rates for telecommunications services are costly enough to deter rural health care providers from demanding excessive levels of telecommunications service.⁶⁴ USAC also reports that there are a number of other factors that have served to reduce demand, which we discuss below. Accordingly, we conclude that, beginning with the third funding cycle, the universal service support mechanism for health care providers will support all commercially available telecommunications services necessary for the provision of health care services, and

⁵⁸ See 47 U.S.C. § 254(h)(1)(A).

⁵⁹ *Universal Service Order*, 12 FCC Rcd at 9142, para. 707.

⁶⁰ *Universal Service Order*, 12 FCC Rcd at 9141, para. 705.

⁶¹ USAC Report at 3.

⁶² *Id.* at 2.

⁶³ *Id.*

⁶⁴ See Advisory Committee Report at 1-2.

that this expansion of eligible telecommunications services will not increase demand beyond the funding cap.

20. The Commission's initial decision to limit support to a T-1 or some combination of lesser services was based upon two factors that are now irrelevant, given that there is little risk of demand exceeding the cap. First, the Commission's initial decision to limit support to a T-1 or some combination of lesser services was based in part upon a finding that the record did not demonstrate that rural health care providers would require higher bandwidths than T-1.⁶⁵ Specifically, the Commission found that the Advisory Committee and the majority of commenters who recommended a specific level of telecommunications bandwidth recommended a capacity of up to and including 1.544 Mbps or its equivalent.⁶⁶ The Advisory Committee and the majority of commenters contended that rural health care providers did not need higher bandwidths for the provision of health care services, and that the cost of higher bandwidth connections would outweigh the benefits.⁶⁷ It is still unclear to us whether rural health care providers need services with greater or lesser bandwidth than 1.544 Mbps for the provision of health care. On the one hand, the Rural Utilities Service (RUS) argues that the current supported bandwidth of 1.544 Mbps may be inadequate because, with the rapid evolution of high-speed broadband networks approaching the 1.544 Mbps capability, the medical community's needs are expected to significantly exceed this level in the near future.⁶⁸ On the other hand, the National Rural Health Association (NRHA) asserts that it appears that many telehealth applications are moving away from dedicated point-to-point T-1 type services to switched, lower bandwidth applications such as ISDN and POTs.⁶⁹ Further, a letter jointly filed by the American Telemedicine Association, the American College of Nurse Practitioners, the Association of Telemedicine Service Providers, and the NRHA states that:

The program should include discounts for all forms of communications services when used in the delivery of health care to rural health care providers. As currently designed, services eligible for the rural health care program are effectively limited to a T1 line, largely because of the use of distance costs associated with this service. However, advancements over the past few years in technology and communications have enabled health care providers to transmit and receive information at speeds lower than that required of T1 lines. Although

⁶⁵ *Universal Service Order* at 9103, para. 622 (citations omitted).

⁶⁶ *Id.* at 9101, para. 621 (citations omitted).

⁶⁷ *Id.* at 9103, para. 622 (citations omitted).

⁶⁸ RUS comments at 4.

⁶⁹ NRHA comments at 1.

lower in cost, this still remains an impediment to many health providers due to the few resources available in support of rural health care.⁷⁰

21. We, therefore, affirm our finding in the *Universal Service Order* that rural health care providers are best able to determine what telecommunications services best meet their needs;⁷¹ moreover, we find that allowing rural health care providers to choose the transmission speeds necessary for health care services in rural areas, outweigh our need to determine with certainty the required bandwidth. Accordingly, we conclude that, given that the per-location funding limit is not necessary for keeping demand on the fund within the \$400 million cap, as long as the telecommunications services are necessary for health care services in rural areas, there is little reason to ascertain definitively whether rural health care providers need telecommunications services with greater or lesser bandwidth than T-1.

22. The second reason that the Commission decided to support only bandwidths up to 1.544 Mbps was because it agreed with the parties who weighed the cost of higher services against the benefits⁷² and found that the limited data suggested that the cost of higher bandwidths could unnecessarily increase the cost of the program by a significant amount.⁷³ While very few respondents to the *USAC Report Public Notice* discussed the cost of supporting higher services, the USAC Report suggests that the cost of higher bandwidths would not unnecessarily increase the cost of the program by a significant amount.⁷⁴

23. More importantly, it appears from the record, particularly the USAC Report, that maintaining the current limits on services does not adequately serve the public interest. That is, regardless of whether rural health care providers need services with greater or lower bandwidth, the public interest would be better served by allowing rural health care providers to have affordable access to all modern telecommunications services necessary to provide medical services. The majority of interested parties in this proceeding assert that the per-location funding limit imposed by the Commission's rules increases the cost of participating in the program, while reducing the value of the potential benefit that a rural health care provider may receive. For example, USAC reports that one of the costs of the restriction is that it discourages some rural

⁷⁰ USAC Report at Appendix B, page 54.

⁷¹ See *Universal Service Order*, 12 FCC Rcd at 9103, para. 622 (citations omitted).

⁷² *Id.*

⁷³ *Id.* at n.1617.

⁷⁴ USAC Report at 41-42.

health care providers from seeking services.⁷⁵ This is in part because of the complexity of securing some combination of services of less than 1.544 bandwidth.⁷⁶ Specifically, in May 1999, USAC reported that "calculation of the PLFL for each applicant to this program has taken a significant amount of effort by carriers and RHCD staff."⁷⁷ Consistent with the findings reported by USAC, RUS asserts that the Commission's rules significantly limit the value of the support provided by the program.⁷⁸

24. Finally, we reject the argument by USTA that any change to the Commission's rules that would expand the class of eligible services would be inconsistent with the Act.⁷⁹ Although USTA admits that the per-location funding limit could be made simpler to administer,⁸⁰ USTA argues that the Commission should not expand the scope of eligible services for the sole purpose of increasing demand to the level that we previously anticipated would be reached.⁸¹ We agree with USTA that the Commission should not expand the scope of eligible services solely for the sake of increasing demand. Instead, we expand the scope of eligible services because the current restrictions are in large part the result of the per-location funding

⁷⁵ *Id.* at 35. See also RUS comments at 4; Letter from James Bradford Ramsay, the National Association of Regulatory Utility Commissioners, to Irene Flannery, FCC (filed Sept. 9, 1999).

⁷⁶ Alaska comments at 4.

⁷⁷ Letter from Robert Haga, USAC, to Magalie Roman Salas, FCC, at 5 (filed May 14, 1999) (USAC letter). USAC further reported that,

carriers filling out Form 468 typically calculate the PLFL using the actual circuit distance rather than the maximum allowable distance (MAD), as specified in the Form 468 instructions. If the circuit distance is very short or zero (for some services, the metered circuit distance may be zero or only to the carrier's nearest office), the PLFL may appear very small. To recalculate the PLFL using the MAD, we must contact carriers to determine what a hypothetical T-1 to the MAD would cost. This may be complicated as the carrier may not offer a T-1 circuit and/or does not know the rate beyond their territory. We must then go to additional carriers in the state to complete the calculation.

Id.

⁷⁸ RUS comments at 4.

⁷⁹ See USTA comments at 7.

⁸⁰ Notice of *Ex Parte* Presentation, from Mary Henze, USTA, to Magalie Roman Salas, FCC (April 29, 1999) at 2 (USTA *ex parte*).

⁸¹ *Id.*

limit, and for the reasons discussed above, we now reject the per-location funding limit. The per-location funding limit is not necessary to ensure that demand for support remains below the \$400 million per year cap. We find that demand will be sufficiently limited by the statutory requirement that supported telecommunications services must be necessary for the provision of health care. Moreover, as previously discussed, we find that a rural health care provider is ill served by our current rule, which further limits the rural health care provider's choices to telecommunications services within bandwidths up to and including 1.544 Mbps, and limits the total amount of support that a rural health care provider can receive to the cost of one T-1 connection.⁸² We believe that a rural health care provider may under some circumstances need, for the provision of health care services, telecommunications services with a higher bandwidth than 1.544 Mbps; a single service with a lesser bandwidth that requires more support than a T-1; or a number of services with lesser bandwidth that together require more support than one T-1. Accordingly, while we recognize that removing the per-location funding limit will potentially increase the amount of support for services that are already eligible for support, and expand the list of eligible services, we conclude that this result is consistent with the Act.

B. Long Distance Charges

1. Background

25. When the Commission first sought to identify which services to support, the Joint Board declined to recommend support for charges for transmissions crossing LATA boundaries, because the record had insufficient information about the cost of reducing or eliminating such charges to justify such a recommendation.⁸³ After seeking further comment on these issues, the Commission found no need for the rural health care mechanism to provide support for LATA crossing charges,⁸⁴ because the statute already requires that rates charged to health care providers in rural areas be no higher than the rates charged in urban areas.⁸⁵ In addition, the Commission

⁸² See 47 C.F.R. § 54.613(b).

⁸³ *First Recommended Decision*, 12 FCC Rcd at 428, para. 672.

⁸⁴ *Universal Service Order*, 12 FCC Rcd at 9132, para. 682.

⁸⁵ *Id.* Section 254(g) states:

rates charged by providers of interexchange telecommunications services to subscribers in rural and high cost areas shall be no higher than the rates charged by each such provider to its subscribers in urban areas.

47 U.S.C. § 254(g).

noted that, to the extent that the term "LATA-crossing charges" refers to access charges for a service provided to a rural customer, the mechanisms adopted in the *Universal Service Order* would support such charges by supporting the difference between the rural rate and the urban rate.⁸⁶ Finally, the Commission noted that, with increasing competition, charges related to LATA crossing are likely to become less burdensome.⁸⁷ On the other hand, USAC reports that one of the barriers to greater participation in the rural health care support program is the lack of support for long distance service.⁸⁸

2. Discussion

26. Based upon the information in this record, we remain unconvinced that the rural health care program should provide additional support for long distance and toll charges, with the exception of support for toll charges incurred by accessing an Internet service provider (for those unable to secure toll-free Internet access). We find that section 254(h)(1)(A) does not obligate telecommunications carriers to deliver service to rural health care providers at rates that are less than those charged to urban health care providers. We note that section 254(h)(1)(A) directs telecommunications carriers to deliver service to rural health care providers at rates that are reasonably comparable to those charged to health care providers in urban areas of the state. Further, we note that, although many of the commenters argue that using long distance service makes it more expensive for rural health care providers to engage in the practice of telemedicine, none have argued that telecommunications carriers charge more for long distance service provided to rural health care providers than for similar service provided to urban residents.⁸⁹ Based on the record before us, therefore, we find no basis for providing additional support for long distance and toll charges.

C. Urban/Rural Rate Calculation

⁸⁶ *Universal Service Order*, 12 FCC Rcd at 9132, para. 682.

⁸⁷ *Id.* at para. 683.

⁸⁸ USAC Report at 4.

⁸⁹ For example, the Utah Department of Health argues that the long-distance telecommunications cost is more of an issue for rural health care providers than the cost of the services provided. Utah Department of Health comments at 1. The Office for the Advancement of Telehealth, Health Resources and Services Administration of the Health and Human Services Department (OAT) reports that "the program's eligible telecommunications services do not cover important services such as toll services or the distance component of ISDN or frame relay," and that these services are "critical to many telemedicine projects and often more costly for users in rural areas." OAT comments at 2. RUS similarly argues that "[l]ong distance and toll charges are among the increased costs of rural telemedicine compared to urban telemedicine," and that "the medical expertise available in most urban centers is more than just a local call away from rural areas." RUS comments at 4.

1. Background

27. Section 254(h)(1)(A) states that "[a] telecommunications carrier shall ... provide telecommunications services ... to any public or non-profit health care provider ... at rates that are reasonably comparable to rates charged for similar services in urban areas in that State."⁹⁰ The Joint Board recommended that the Commission define the "urban rate" as the highest tariffed or publicly available rate actually being charged to commercial customers within the jurisdictional boundary of the nearest large city in the same state as the rural health care provider.⁹¹ The Joint Board further recommended that "comparable" be defined as no higher than the highest rate charged in the nearest large city.⁹² Although the Advisory Committee stated that support for some distance-based charges is necessary to ensure that rates charged to rural health care providers are "reasonably comparable" to urban rates,⁹³ the Joint Board declined to recommend support for distance-based charges because it concluded that the record lacked sufficient evidence upon which to base such a recommendation.⁹⁴

28. The Commission agreed with the Joint Board and interpreted section 254(h)(1)(A) as requiring telecommunications carriers to charge rural health care providers a rate for supported service that is no higher than the highest tariffed or publicly available rate charged by a carrier to a commercial customer for a similar service, in the state's closest city.⁹⁵ Based upon the recommendation of the Joint Board, the Commission also determined that the closest city would be the city, measured by airline miles from the rural health care provider's location to the closest point on the city's boundary, with a population of at least 50,000.⁹⁶

29. After gathering additional information, the Commission concluded that the rural health care support mechanism shall include, in the calculation for support, the distance-based

⁹⁰ 47 U.S.C. § 254(h)(1)(A).

⁹¹ *First Recommended Decision*, 12 FCC Rcd at 426, para. 667; *see also Universal Service Order*, 12 FCC Rcd at 9124, para. 667.

⁹² *Id.*

⁹³ Advisory Committee Report at 2.

⁹⁴ *First Recommended Decision*, 12 FCC Rcd at 428, para. 672; *see also Universal Service Order*, 12 FCC Rcd at 9124, para. 668.

⁹⁵ *Universal Service Order*, 12 FCC Rcd at 9093, para. 608.

⁹⁶ *Id.* at 9121, para 670.

charges for the distance between the rural health care provider and the nearest large city.⁹⁷ The Commission defined "distance-based charges" as charges based on a unit of distance, such as mileage-based charges.⁹⁸ Recognizing that urban health care providers are not exempt from distance-based charges in connection with their purchase of telecommunications services, the Commission took into account the potential distance-based charges paid by urban providers on a statewide basis. The Commission did this by directing the Administrator to take the longest diameters of all cities with a population of 50,000 or more within each state, and to average them to arrive at each state's standard urban distance (SUD).⁹⁹ The Commission then instructed the Administrator to treat a rural health care provider as if it is located in the nearest large city in the state.¹⁰⁰ That is, if a rural health care provider requested that a service be provided over a distance that is less than or equal to its state's SUD, then the rural health care provider would have to pay the actual rate charged for a similar service provided over the same distance in the nearest large city.¹⁰¹ If the rural health care provider requested that a service be provided over a distance that is greater than its state SUD, the rural health care provider would only have to pay the rate charged for a similar service provided over the SUD.¹⁰²

30. The Commission explained that it is consistent with the statute to consider distance-based charges because, "many, if not most, base rates for telecommunications services are averaged across a state or study area. It is often distance-based charges, not differences between base rates for service elements, that create great disparities in the overall cost of telecommunications services between urban and rural areas."¹⁰³ The Commission further noted that several local exchange carriers (LECs) contend that a rural rate is "reasonably comparable" to an urban rate provided that per-mile charges are the same for rural and urban areas.¹⁰⁴ Based upon this record, the Commission determined that ensuring that rates charged to rural health care providers are "reasonably comparable" to urban rates requires support for not only the difference

⁹⁷ *Id.* at 9128, para. 674.

⁹⁸ *Id.*

⁹⁹ *Id.* at 9131, para. 680.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 9131, para. 681.

¹⁰² *Id.*

¹⁰³ *Id.* at 9128, para. 675 (citations omitted).

¹⁰⁴ *Id.*

in base rates, but for some distance-based charges as well.¹⁰⁵

31. According to the USAC Report, the current method of calculating support is so complex and time consuming that many rural health care providers and carriers have been reluctant to participate in the program.¹⁰⁶ USAC proposes resolving the problems associated with ascertaining the rate differential in one of two ways: (1) by establishing statewide average discount percentages to apply to the rural base rates and/or distance sensitive charges for eligible services; or (2) by recognizing that long-distance charges represent a rate difference between urban and rural service, and, therefore, using long-distance charges as the basis for support.¹⁰⁷ USTA, on the other hand, proposes that the Commission determine that most charges, other than mileage, for telecommunications service in rural areas are already comparable to those in urban areas.¹⁰⁸ USTA, therefore, urges the Commission to focus on supporting all actual distance-based charges, minus a "standardized standard urban distance," up to a maximum allowable distance.¹⁰⁹ USTA further suggests that, in the few cases where there is a difference between the base rates for services in urban and rural areas, the Commission should give rural health care providers the option to request a more comprehensive rate comparability calculation along the lines of the current process.¹¹⁰

2. Discussion

32. In light of the entire record now before us, we determine that most of the base rates for telecommunications service elements charged to rural health care providers are already reasonably comparable to those charged in urban areas. This position is consistent with USTA's recommendation.¹¹¹ Accordingly, we conclude that the Administrator need not compare the tariffed or publicly available base rates for telecommunications service elements to determine the amount of support that it can provide for the benefit of a rural health care provider. We, therefore, direct that, beginning with the third funding cycle, the Administrator must calculate

¹⁰⁵ *Id.*

¹⁰⁶ USAC Report at 5.

¹⁰⁷ *Id.* at 4.

¹⁰⁸ USTA *ex parte* at 2.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ See USTA *ex parte* at 3.

support based upon all actual distance-based charges.

33. At the time that the rural health care program was established, the Commission did not realize the extent to which directing the parties to identify the highest tariffed or publicly available rate actually being charged to urban customers, in order to set rates for telecommunications services "that are reasonably comparable to rates charged for similar services in urban areas in that State," would consume an unwarranted amount of resources for very little benefit. In the *Universal Service Order*, the Commission specifically acknowledged that most base rates for telecommunications services are averaged across a state or study area, and concluded, therefore, that it is often the distance-based charges that account for the difference between the urban and rural rates charged to rural health care providers.¹¹² As a result, the Commission directed that, in addition to providing rural health care providers with support for the difference between the highest tariffed or publicly available rate actually being charged to urban customers and the rate charged to the rural health care providers (i.e. the base rates for telecommunications service elements), the Administrator must also provide support for distance-based charges.¹¹³ We have since learned that, because of the need to refer to the various tariffs,¹¹⁴ calculating the difference between the urban and rural base rates for telecommunications service elements is extremely labor intensive.¹¹⁵ For many carriers and rural health care providers, the cost of calculating the difference between the urban and rural base rates for telecommunications service elements outweighs the benefits of participating in the rural health care program, because it is the distance charges that account for the rate differences of any significance.¹¹⁶ For example, Alaska argues that FCC Forms 466 and 468 should be simplified because,

[r]equirements for detailed diagramming of circuits have proven confusing and

¹¹² *Universal Service Order*, 12 FCC Rcd at 9129, para. 675.

¹¹³ *Id.*

¹¹⁴ See 47 C.F.R. § 54.605(b). Section 54.605(b) of the Commission's rules provides that:

If a rural health care provider requests an eligible service to be provided over a distance that is greater than the "standard urban distance" for the state in which it is located, the urban rate shall be no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a similar service provided over the standard urban distance in the nearest large city in the state, calculated as if the service were provided between two points within the city.

Id.

¹¹⁵ See USAC letter at 5; USAC Report at 33.

¹¹⁶ USTA *ex parte* at 2.

time-consuming to some LECs in Alaska. Rural health care providers throughout the State have often encountered complaints or resistance from telecommunications carriers with respect to this task. Moreover, the information is also of questionable value, particularly when the rate for the service provided is not distance-sensitive.¹¹⁷

Because the failure to properly calculate the difference between the urban and rural base rates for telecommunications service elements must be corrected by the Administrator, this activity has proven to be a burden for the Administrator as well.¹¹⁸

34. We, therefore, simplify the method for calculating support found in section 54.609 of the Commission's rules.¹¹⁹ Consistent with the approach proposed by USTA in

¹¹⁷ Alaska comments at 4.

¹¹⁸ USAC letter at 5; USAC Report at 5.

¹¹⁹ The process for calculating support under the current rules is as follows. According to section 54.609 of the Commission's rules, the amount of support due to a carrier for providing an eligible telecommunications service to an eligible rural health care provider is equal to the difference between the urban and rural rates. 47 C.F.R. § 54.609. The urban rate depends on the standard urban distance of the state in which the health care provider is located. 47 C.F.R. § 54.605. It is the responsibility of RHCD to establish the "standard urban distance." *Id.* The standard urban distance is the average of the longest diameters of all cities with a population of 50,000 or more within the state. *Id.* If the requested service distance is less than or equal to the "standard urban distance" for the state, the charge for that service can be no higher than the rate charged for a similar service transmitted the length of the "standard urban distance" in the large city nearest to the rural health care provider (urban rate). *Id.* If the requested service distance is greater than the "standard urban distance" for the state, but less than the maximum allowable distance (i.e., the distance between the rural health care provider and the point on the boundary of the nearest large city, that is most distant from the location of the rural health care provider), the charge for that service can be no higher than the rate charged for a similar service in the large city nearest to the health care provider (urban rate) over the standard urban distance. *Id.* If the requested service distance is greater than the maximum allowable distance, the charge for that service can be no more than the rate charged for a similar service, transmitted the length of the SUD, in the large city nearest to that rural health care provider (urban rate), plus the distance charges based on the rural rate for the distance that exceeds the allowable distance. *Id.*

Carriers can determine the amount of credit or reimbursement for which they qualify by subtracting from the rural rate the urban rate that would have been charged to the eligible rural health care provider if it were an urban subscriber to the service. 47 C.F.R. § 54.609. The rural rate, used to determine the credit or reimbursement that must be given to a carrier, is the average of the rates charged to commercial customers, other than health care providers, for identical or similar services in the same rural area in which the rural health care provider is located. 47 C.F.R. § 54.607. If there are no tariffed or publicly available rates for such services in the rural area, or if the carrier reasonably determines that the method for calculating the rural rate is unfair, the carrier can, in accordance with section 54.607(b)(1)-(2) of the Commission's rules, submit for the state commission's approval (for intrastate rates) or the Commission's approval (for interstate rates), a cost-based rate for providing the service in the most

response to the *USAC Report Public Notice*, we direct the Administrator to consider the base rates for telecommunications services elements in rural areas to be reasonably comparable to the base rates charged for similar telecommunications service elements in urban areas in that state. The Administrator, therefore, shall not include these charges in calculating support. In addition, we direct the Administrator to treat a rural health care provider as if it is located in the nearest large city in the state, in the same manner as it does under the current rules.¹²⁰ That is, if the requested service distance is less than or equal to the SUD for the state, the distance-based charge for that service can be no higher than the distance-based charged for a similar service over the same distance in the large city nearest to the rural health care provider.¹²¹ If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge for that service can be no higher than the distance-based charged for a similar service, transmitted the length of the SUD, in the large city nearest to the rural health care.¹²²

35. Consistent with the approach proposed by USTA, we also conclude that, in the event a rural health care provider or carrier can establish that there is a difference between the urban and rural base rates charged for a telecommunications service, the rural health care provider or the telecommunications carrier may request a more comprehensive rate comparability calculation consistent with the Commission's current rules.¹²³ We note that it would not be feasible for the Administrator to document the tariffed or publicly available urban rates for all commercially available telecommunications services to establish a benchmark for comparison of

economically efficient, reasonably available manner. *Id.*

¹²⁰ See 47 C.F.R. § 54.605.

¹²¹ *Id.*

¹²² *Id.* The following examples illustrate the application of this method of calculating support. If the SUD is 10 miles, and the distance from the nearest large city to the rural health care provider is 9 miles, the rural health care provider would not qualify for support for the distance-based charges, because the distance-based charges would amount to no more than would generally be required of a health care provider located within the nearest large city. If the distance from the nearest large city to another rural health care provider is 110 miles, the carrier must treat the rural health care provider as if it is located in the nearest large city, and, therefore, may not charge that rural health care provider for a distance greater than the SUD (10 miles). Consequently, if the carrier charges \$10 per mile, it may only charge the second rural health care provider \$100. The carrier must send an invoice to RHCD to obtain reimbursement for the balance (\$1,000). In the event that the maximum allowable distance is 100 miles, RHCD may not consider any distance above 100 miles in calculating the support. As in the previous scenario, treating the rural health care provider as if it is located within the nearest large city would require the rural health care provider to pay \$100; however, because RHCD would not authorize reimbursement for any mileage greater than the MAD, the carrier would also charge the rural health care provider for the extra 10 miles. Consequently, the rural health care provider would have to pay a total of \$200, and the carrier would be entitled to reimbursement for \$900.

¹²³ See 47 C.F.R. §§ 54.605, 54.607.

the base rates of telecommunications service elements. Consequently, in the rare instance where there is a difference between the urban and rural base rates for services, we require the rural health care provider or carrier to provide the evidence thereof.

36. We do not modify our rules to require the Administrator to deduct a standardized SUD from the total distance-based charge. We believe that such an approach would generally result in establishing a national SUD to calculate the support amount. We reject this approach because the Administrator has already established the average of the longest diameters of all cities with a population of 50,000 or more within each state, and adding the state averages together to ultimately arrive at a national SUD would not be as accurate as using each state's SUD. We also reject this suggestion because we believe that it would not result in rural health care providers paying distance-based charges that are reasonably comparable to those required of urban subscribers as required by section 254(h)(1)(A), since it would require a rural health care provider to pay the balance of the distance-based charge. We find that this balance would generally be more than urban subscribers are required to pay.

37. We reject USAC's proposal to establish statewide average discount percentages to apply to the rural base rates and/or distance sensitive charges for eligible services.¹²⁴ Section 254(h)(1)(A) requires the Commission to adopt mechanisms designed to make telecommunications services available to rural health care providers at rates reasonably comparable to "*rates charged* for similar services in urban areas."¹²⁵ As the Joint Board previously stated, however, use of an average rate "would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems for those urban customers and arguably going farther with this mechanism than Congress intended."¹²⁶

D. Equipment

1. Background

38. Section 254(c)(3) provides that, in addition to the "core" services described under the provisions of section 254(c)(1), the Commission "may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)."¹²⁷ The Joint Board made no recommendation as to the exact scope of services to be supported, and

¹²⁴ See USAC Report at 4.

¹²⁵ 47 U.S.C. § 254(h)(1)(A) (emphasis added).

¹²⁶ *First Recommended Decision*, 12 FCC Rcd at 428, para. 672.

¹²⁷ 47 U.S.C. § 254(c)(1).

recommended, instead, that the Commission solicit information and expert advice on the exact scope of services that are "necessary for the provision of health care in a state."¹²⁸ The Joint Board recommended support only for telecommunications services, and not for internal connections or customer premises equipment.¹²⁹ Consistent with the recommendation of the Joint Board, the Commission issued the *Recommended Decision Public Notice*, seeking information about the exact scope of services that should be included in the definition of services "necessary for the provision of health care in a State," and the most cost-effective way to provide such services.¹³⁰ The Commission ultimately agreed with the Joint Board and declined to provide universal service support for equipment.¹³¹

39. The USAC Report, however, again raises the issue of support for equipment. The USAC Report notes that, because equipment purchases for telemedicine can be a major investment, some rural health care providers cannot afford to acquire the equipment, and, therefore, cannot take advantage of the support for telecommunications services offered by the program.¹³² The USAC Report makes no recommendation regarding support for equipment.

2. Discussion

40. Section 254(h)(1)(A) does not authorize the provision of universal service support for equipment needed by rural health care providers to establish telemedicine programs. We note that section 254(h)(1)(A) directs telecommunications carriers to provide telecommunications services to rural health care providers at a discounted rate, and permits the telecommunications carriers to have the amount of the discount treated as part of their obligation to participate in the mechanisms to preserve and advance universal service. There is nothing in section 254(h)(1)(A) that authorizes the provision of universal service support for the purchase of equipment by rural health care providers. Indeed, the Joint Explanatory Statement indicates that Congress' intent was that "the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services."¹³³ Consistent with the

¹²⁸ *First Recommended Decision*, 12 FCC Rcd at 421, para.656.

¹²⁹ *Id.*

¹³⁰ *Recommended Decision Public Notice* at 2.

¹³¹ *Universal Service Order*, 12 FCC Rcd at 9105, para. 626.

¹³² USAC Report at 37.

¹³³ Joint Explanatory Statement of the Committee of the Conference (H.R. Rep. No. 458, 104th Cong., 2d Sess.) (Joint Explanatory Statement) at 133.

Joint Explanatory Statement, USTA argues that it would be inappropriate and unlawful to provide support for equipment, or any other non-telecommunications service component of telemedicine.¹³⁴ RUS similarly opposes providing support to reduce the cost of any non-telecommunications service expenses of telemedicine.¹³⁵ RUS notes that other federal programs, such as the RUS Distance Learning and Telemedicine Loan and Grant Program are available to assist with the financing of end-user hardware and facilities used in telemedicine projects.¹³⁶ Under these circumstances, we conclude that the rural health care support mechanism cannot assist in reducing the cost of the equipment necessary for rural health care providers to provide telemedicine services.

E. Insular Areas

1. Background

41. Section 254(h)(1)(A) directs telecommunications carriers to provide telecommunications services to rural health care providers "at rates that are reasonably comparable to rates charged for similar services in *urban areas in that State*."¹³⁷ Consistent with the recommendation of the Joint Board, the Commission defined the "urban area" to mean the city in the state with a population of at least 50,000 nearest to the rural health care provider's site.¹³⁸ In the *Universal Service Order*, the Commission noted that the provisions of section 254(h)(1)(A) apply to insular areas, because the Act defines "State" to include all United States "[t]erritories and possessions."¹³⁹ The Commission found, however, that most insular areas do not have a city with a population as large as 50,000, and hence have no recognizable urban area.¹⁴⁰ Therefore, the Commission designated the largest population centers in the insular areas as urban areas, for purposes of calculating the urban/rural rate differential, that would form the basis for determining the amount of universal service support received by rural health care

¹³⁴ USTA comments at 7.

¹³⁵ RUS comments at 4.

¹³⁶ *Id.*

¹³⁷ 47 U.S.C. § 254(h)(1)(A) (emphasis added).

¹³⁸ *Universal Service Order*, 122 FCC Rcd at 9125, para. 669.

¹³⁹ 47 U.S.C. § 153(40); see *Universal Service Order*, 12 FCC Rcd at 9135, para. 692. The term "insular area," as used in the *Universal Service Order*, includes but is not limited to, American Samoa, the U.S. Virgin Islands, Commonwealth of the Northern Mariana Islands (CNMI), Guam, and Puerto Rico. *Universal Service Order*, 12 FCC Rcd at 9136, para. 695 n. 1820.

¹⁴⁰ *Universal Service Order*, 12 FCC Rcd at 9136, para. 694.

providers in insular areas.¹⁴¹ The Commission further acknowledged that, because of the lack of information in the record regarding the telecommunications needs of insular areas and the costs of supporting such services, the Commission would issue a public notice to better address those issues.¹⁴²

42. Since issuing the *Universal Service Order*, the Commission has learned that, as currently calculated, there is very little difference between the rates for telecommunications services in the "urban" and "rural" parts of the insular areas.¹⁴³ As a result, the rural health care providers in these areas will receive very little support for the first and second funding years of the program.¹⁴⁴ In addition, a number of the rural health care providers in these insular areas have indicated that advanced medical services are often unavailable within the insular areas, so there would be little medical benefit to having access to modern telecommunications services that permit connection only to medical facilities within the insular areas.¹⁴⁵ Accordingly, these rural health care providers seek rates that are reasonably comparable to rates charged for similar telecommunications services in urban areas *outside of the insular areas*.¹⁴⁶

2. Discussion

43. Because we still lack sufficient information to ensure that health care providers located in the insular areas have access to the telecommunications services available in urban areas in the country at affordable rates, on August 5, 1999, the Commission adopted the *Unserved, Tribal, and Insular Areas FNPRM* seeking public input on these and many related issues.¹⁴⁷ We note that the record here contains insufficient information about the status and availability of health care services and telemedicine in most of the insular areas.

44. We are concerned that, to the extent that section 254(h)(1)(A) was intended solely to help equalize the rates paid by residents of urban and rural areas within a state, the Commission would be constrained in its ability to provide relief to rural health care providers in

¹⁴¹ *Id.* at 9136-38, paras. 693-699.

¹⁴² *Id.* at 9137, para. 696.

¹⁴³ See USAC Report at 37.

¹⁴⁴ *Id.*

¹⁴⁵ RUS comments at 5; CNMI comments at 1-3.

¹⁴⁶ CNMI comments at 4 (emphasis added).

¹⁴⁷ See note 29 *supra*.

the insular areas. We note that Congress could have provided discounts on the telecommunications service that rural health care providers use to connect to the nearest *major urban hospital within or outside the state* when rural health care providers rely on such hospitals for consultations. This approach would have directed assistance to rural health care providers hindered by the high costs of linking to major hospitals they need to reach outside of their states. Moreover, the Act could have sought to equalize rates paid by rural health care providers in different states, ensuring that no rural health care provider paid significantly more than hospitals in the largest urban areas, regardless of state boundaries. The language of section 254(h)(1)(A), however, merely directs the Commission to provide universal service support to rural health care providers to enable them to pay rates similar to those paid in urban areas *of their states*.¹⁴⁸

45. On the other hand, we have always recognized that our method for determining the amount of support that a rural health care provider may receive is ill suited to insular areas. In the *Universal Service Order*, for example, we noted that ninety-five percent of American Samoa's population of 56,000 lives on the island of Tutuila, where the territory's single hospital is located.¹⁴⁹ Since we designated Tutuila as an urban area for purposes of setting the urban rate, rural health care providers in American Samoa will be constrained in their ability to take full advantage of the benefits of the rural health care support mechanism.

46. The Commission concluded in the *Universal Service Order* that section 254(h)(2)(A) authorizes the Commission to adopt special mechanisms to calculate support for the insular areas.¹⁵⁰ Section 254(h)(2)(A) directs the Commission, in part, to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications ... services for all public and nonprofit ... health care providers."¹⁵¹ In order to implement the statute's directives, among other things, we need to identify the necessary services and determine what is "technically feasible and economically reasonable." That is, we need additional data about the specific needs of insular areas in this context, as well as the estimated cost of providing such support for those needs. We also note that, were we to grant support for links between rural health care providers in insular areas and the nearest advanced health care facilities in some other jurisdiction, we would need to set standards for identifying such facilities. We would also need to ensure that such rules would not be inconsistent with state physician licensing requirements that might preclude a rural health care provider from establishing a telemedicine connection with an advanced facility in the nearest

¹⁴⁸ 47 U.S.C. § 254(h)(1)(A) (emphasis added).

¹⁴⁹ *Universal Service Order*, 12 FCC Rcd at 9137, para. 695.

¹⁵⁰ *Id.* at 9135, para. 692.

¹⁵¹ 47 U.S.C. § 254(h)(2)(A).

large city in another state. Consequently, we encourage interested parties to submit their comments in the *Unserved, Tribal, and Insular Areas FNPRM* proceeding that we initiated on August 5, 1999,¹⁵² as we will be addressing these issues in the near future.

IV. ELIGIBILITY OF HEALTH CARE PROVIDERS

A. Definition of Health Care Provider

1. Background

47. Section 254(h)(1)(A) authorizes telecommunications carriers to provide discounted telecommunications services to any public or non-profit health care provider that serves rural areas in a state. Section 254(h)(5)(B) lists seven categories of entities that are included in the definition of "health care provider."¹⁵³ The Advisory Committee suggested including non-profit nursing homes and other long-term care facilities, as well as non-profit home health care providers in rural areas.¹⁵⁴ The Advisory Committee argued that this group of health care providers can use telecommunications services for making electronic house-calls to the elderly, chronically ill, and homebound mentally ill.¹⁵⁵ The Joint Board found that the statute adequately describes the entities intended by Congress to be eligible for universal service support, and recommended that the Commission attempt no further clarification of the term "health care provider."¹⁵⁶ The Commission adopted the Joint Board's recommendation and used

¹⁵² See note 29 *supra*.

¹⁵³ Section 254(h)(5)(B) defines the term "health care provider" as:

- (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- (ii) community health centers or health centers providing health care to migrants;
- (iii) local health departments or agencies;
- (iv) community mental health centers;
- (v) not-for-profit hospitals;
- (vi) rural health clinics;
- (vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).

47 U.S.C. § 254(h)(5)(B).

¹⁵⁴ Advisory Committee Report at 14.

¹⁵⁵ *Id.* at 15.

¹⁵⁶ *First Recommended Decision*, 12 FCC Rcd at 444, para.711.

the list from the statute to define "health care provider."¹⁵⁷ USAC reports that many rural health care providers believe that the Commission has too narrowly defined the term "health care provider,"¹⁵⁸ and it suggests that the Commission expand or clarify the definition to include rural nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.¹⁵⁹

2. Discussion

48. We affirm our initial conclusion that section 254(h)(5)(B) adequately describes those entities Congress intended to be eligible for universal service support.¹⁶⁰ We find that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities, it would have done so explicitly.¹⁶¹ Thus, we find that the definition of "health care provider" does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.

49. Moreover, we clarify that a rural nursing home is ineligible to receive universal service support from the rural health care support mechanism, whether or not it is part of a not-for-profit hospital or rural health clinic. We are not persuaded that an entity omitted from the list in the statute should be allowed to apply for and receive the benefits of the program directly from the universal service support mechanism simply because of the relationship between the ineligible and eligible entity. Moreover, we find no rational basis for distinguishing between a rural nursing home that is part of a not-for-profit hospital or rural health clinic and a rural nursing home that is associated with any of the other categories of eligible entities listed in the statute. Finally, we believe that allowing nursing homes to receive support directly from the rural health care support mechanism based upon their association with eligible entities would very likely result in a flood of other types of ineligible entities requesting similar treatment, and thus would render meaningless the limitations imposed by Congress in section 254(h)(5)(B). We find, therefore, that, to the extent that the instructions for the current version of the FCC Form 465 state that nursing homes that are "part of a not-for-profit hospital or rural health care clinic" are health care providers eligible to receive support, those instructions are incorrect.

¹⁵⁷ See 47 C.F.R. § 54.604.

¹⁵⁸ USAC Report at 36.

¹⁵⁹ *Id.*

¹⁶⁰ See *Universal Service Order*, 12 FCC Rcd at 9117, para. 653.

¹⁶¹ See *Universal Service Order*, 12 FCC Rcd at 9119, para. 656 (citations omitted).

B. Restrictions on Resale and Aggregated Purchases**1. Background**

50. Section 254(h)(3) states that "telecommunications services and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value."¹⁶² While the Joint Board urged the Commission to strictly enforce section 254(h)(3), it also emphasized that this prohibition should not restrict or inhibit joint purchasing and network-sharing arrangements with both public and private entities and individuals.¹⁶³ Indeed, the Joint Board recommended that health care providers be encouraged to enter into aggregate purchasing and maintenance agreements for telecommunications services with other public and private entities and individuals, as long as the entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services.¹⁶⁴

51. The Commission agreed with the Joint Board and the many commenters who noted that aggregated purchase of network sharing arrangements could substantially reduce costs and, in some cases, are necessary to sustain certain rural telecommunications networks.¹⁶⁵ Consistent with its directives to schools and libraries, however, the Commission concluded that an eligible rural health care provider participating in a consortium that includes private sector members may receive support only if the consortium is receiving tariffed rates or market rates.¹⁶⁶ The Commission explained that "this prohibition will deter ineligible, private entities from entering into aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive."¹⁶⁷ The Commission further explained that it did not believe that such a limitation would inhibit the ability of eligible health care providers to participate in advanced telecommunications services, nor would it deny rural health care providers access to community-based telecommunications facilities.¹⁶⁸

¹⁶² 47 U.S.C. § 254(h)(3).

¹⁶³ *First Recommended Decision*, 12 FCC Rcd at 455, para. 735.

¹⁶⁴ *Id.*

¹⁶⁵ *Universal Service Order*, 12 FCC Rcd at 9146, para. 719 (citations omitted).

¹⁶⁶ *Id.* at 9147, paras. 719-20.

¹⁶⁷ *Id.* at 9147, para. 719.

52. The USAC Report confirms that, in some rural states, rural health care providers bring the only advanced telecommunications networks to their communities.¹⁶⁹ As a result, they are receiving requests to share their networks, throughout the year, from entities such as the National Guard, Girl Scouts, universities, and other public and non-profit community organizations.¹⁷⁰ Based upon the USAC Report, it appears that USAC does not allow rural health care providers to change their applications to add consortium members after USAC determines that the rural health care provider is eligible for support and the rural health care provider submits its selection of a carrier (Form 466). This is presumably because the addition of an ineligible private sector entity would require USAC to redetermine the eligibility of the rural health care provider, and could render a rural health care provider ineligible for support if the consortium was receiving services at less than the published tariff or market rates.

2. Discussion

53. We affirm the conclusion that we reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to abuse of the prohibition on resale.¹⁷¹ Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support. We note that the Commission's rules do not restrict a rural health care provider's ability to join a consortium with other eligible health care providers, or public sector governmental entities (such as schools and libraries).¹⁷² The Commission's rules also do not restrict a rural health care provider's ability to continue to participate in a consortium to which any of the above are added after the rural health care provider applies for universal service support.¹⁷³ The Commission's rules limit a rural health care provider's ability to receive universal service support only if the consortium includes a private sector entity.¹⁷⁴ Section 54.601(b) of the Commission's rules state that, in the event that a

¹⁶⁸ *Id.* at 9148, para. 722.

¹⁶⁹ USAC Report at 36.

¹⁷⁰ *Id.*

¹⁷¹ *See Universal Service Order*, 12 FCC Rcd at 9146, para. 719.

¹⁷² *See* 47 C.F.R. § 54.601(b).

¹⁷³ *Id.*

¹⁷⁴ *Id.*

consortium includes a private sector entity, a rural health care provider may receive support only if the consortium is paying tariffed or market rates for the subject services.¹⁷⁵ We believe that our interpretation is consistent with both the section 254(h)(1)(A) requirement to ensure that health care providers located in rural areas have access to telecommunications services at rates available to urban residents, and the section 254(h)(3) prohibition against the sale, resale, or other transfer of supported services for money.¹⁷⁶

54. We also clarify that a tariffed or market rate received by a consortium of eligible and ineligible entities may include a volume discount, or otherwise reflect consideration of the unique characteristics of the subscribers, to the extent that characteristic is not a rural health care provider's eligibility to receive support from the rural health care program. This is because the Commission's restriction on consortium membership was intended to prohibit ineligible private entities from receiving the benefits of the rural health care support mechanism. The *Universal Service Order* clearly states that the Commission and the Joint Board supported broad-based participation in consortia and intended to encourage their growth.¹⁷⁷ The Commission explained, in the *Universal Service Order*, that this restriction is necessary to "deter ineligible, private entities from entering into aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive."¹⁷⁸ We find that an ineligible private entity that enters into an aggregated purchase arrangement with a rural health care provider, and receives a tariff or market rate that includes a volume discount, would not be receiving a below-tariff or below-market rate because of the eligibility status of a rural health care provider participating in the consortium. We, therefore, find that such an arrangement would not violate our rules, as long as entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services.

55. The section of the *Universal Service Order* that addresses the universal service support mechanism for schools and libraries offers an additional reason for the Commission's

¹⁷⁵ *Id.*

¹⁷⁶ 47 U.S.C. §§ 254(h)(1)(A), 254(h)(3). The Commission's rules provide that the Administrator may not approve support unless it can be demonstrated that the average rate that members of a consortium pay is greater than the applicable urban rate. See *Universal Service Order*, 12 FCC Rcd at 9148, para. 722. We note that, as a practical matter, the risks associated with our clarification are minimal because it is unlikely that many of the carriers providing telecommunications services under a consortium arrangement could be eligible for support under section 254(h)(1)(A) because, rural health care providers obtaining services at rates that include volume discounts are unlikely to be paying more than the urban rate. See *Universal Service Order*, 12 FCC Rcd at 9148, para. 722; see also OAT comments at 2.

¹⁷⁷ *Universal Service Order*, 12 FCC Rcd at 9145-9148, paras. 717-22.

¹⁷⁸ *Id.*

restriction on consortium membership, which would not be contradicted by the finding above.¹⁷⁹ In the section of the *Universal Service Order* that discusses the universal service support mechanism for schools and libraries, the Commission noted that it was concerned that "permitting large private sector firms to join with eligible schools and libraries to seek prices below tariffed rates could compromise both the federal and state policies of non-discriminatory pricing."¹⁸⁰ The Commission found congressional support for permitting eligible schools and libraries to secure prices below tariffed rates, and no basis for extending that exception to enable all private sector firms to secure such prices.¹⁸¹ The Commission concluded that eligible schools and libraries would generally qualify for universal service discounts and prices below tariffed rates for interstate services, only if any consortia they join include only other eligible schools, libraries, rural health care providers, and public sector customers.¹⁸² Although the *Universal Service Order* does not define the term "tariffed rates," the definition of the term "pre-discount price," and the explanation of the Commission's intent in the schools and libraries section of the *Universal Service Order* is instructive in determining whether permitting a consortium of eligible and ineligible entities to obtain tariff rates that include a volume discount could compromise the policies of non-discriminatory pricing. The *Universal Service Order* defines pre-discount price as the price of services to schools and libraries prior to the application of a discount from the universal service support mechanism.¹⁸³ It is "the total amount that carriers will receive for the services they sell to schools and libraries: the sum of the discounted price paid by a school or library and the discount amount that the carrier can recover from universal service support mechanisms for providing such services."¹⁸⁴ The *Universal Service Order* explains:

Although consortia-negotiated prices might commonly be characterized as "discounted prices," because they are lower than the prices that individual members of the consortia would be able to secure on their own, we still characterize them as "pre-discount prices" for the purposes of section 254(h) because they are the prices eligible schools and libraries could obtain even without application of the relevant universal service support discounts. All members of such consortia, including those ineligible for universal service

¹⁷⁹ See *id.* at 9028, para. 477.

¹⁸⁰ *Universal Service Order*, 12 FCC Rcd at 9028, para. 477.

¹⁸¹ *Id.*

¹⁸² *Id.* at 9028, para. 478.

¹⁸³ *Id.* at 9026, para. 473.

¹⁸⁴ *Id.*

support, would benefit from these lower "pre-discount" prices produced by such statewide, regional, or large group contracts.... While those consortium participants ineligible for support would pay the lower pre-discount prices negotiated by the consortium, only eligible schools and libraries would receive the added benefit of universal service discount mechanisms.¹⁸⁵

It is clear from this statement that the Commission's intent as expressed in both the rural health care and schools and libraries sections of the *Universal Service Order* is the same; to wit, to ensure that only eligible entities receive the benefit of the universal service support mechanism, not to prohibit a consortium from taking advantage of the tariff or other publicly available rates that reflect the economies of scale. Accordingly, we conclude that it would not violate section 254, or compromise Federal and state policies of non-discriminatory pricing to permit a rural health care provider to benefit from the rural universal service support mechanism, where the rural health care provider is a member of a consortium of eligible and ineligible entities receiving service at tariffed or other publicly available rates that include a volume discount.

56. The fact that the Commission's rules prohibit a rural health care provider from receiving support if it is in a consortium that includes private sector members, unless the consortium is receiving tariffed rates or market rates,¹⁸⁶ has apparently largely been erroneously interpreted as requiring the consortium members to be paying rates that do not include volume discounts.¹⁸⁷ As a result, commenters such as the Rural Telecommunications Policy Working Group (RTP) and the Health Care Systemic Change Initiative (HCSCI) believe that the Commission's treatment of consortia discourages community-based telecommunications facilities.¹⁸⁸ Consequently, they request that the Commission generally encourage the community use of telecommunications service facilities that the rural health care providers use for telemedicine.¹⁸⁹ Similarly, RUS argues that community use should be allowed because it is not resale.¹⁹⁰

57. We find that, to the extent that the Commission's exception is being narrowly

¹⁸⁵ *Id.* at 9072-73, para 563.

¹⁸⁶ *Id.* at 9147, para. 719; 47 C.F.R. § 54.601(b).

¹⁸⁷ *See, e.g.*, OAT comments at 1.

¹⁸⁸ *Id.*

¹⁸⁹ *See, e.g.*, RTP/HCSCI comments at 3; RUS comments at 6.

¹⁹⁰ RUS comments at 6.

interpreted as requiring a rural health care provider in a consortium with ineligible private entities to receive rates that do not include a volume discount, the interpretation largely defeats the purpose of participating in a consortium, and, therefore, is inconsistent with our intention to encourage participation in consortia. OAT and NTIA provide ample justification for rejecting the narrow interpretation of the terms "tariffed rates" and "market rates." OAT and NTIA indicate that together they support over 400 rural telemedicine sites in the United States, and about ninety percent of those sites organize their networks into formal and informal consortia to achieve greater economic efficiency.¹⁹¹ They further indicate that the consortium typically includes an urban "hub" site such as a medical college, urban hospital, medical center, or state governmental unit associated with several small rural "spoke" sites.¹⁹² According to OAT and NTIA, many rural health care providers use telecommunication infrastructures established and maintained by the "hub" site.¹⁹³ We are not convinced that requiring a consortium to receive tariffed or market rates should mean that the rate cannot take volume into consideration, and reflect the economies of scale. We believe that a better interpretation is one that recognizes that there are tariffed and market rates that include volume discounts, just as there are tariffed and market rates that recognize the unique characteristics of other subscribers of telecommunications service. Consequently, we conclude that entities not explicitly eligible for support cannot gain eligibility for support by participating in consortia with those that are eligible, but every member of the consortium may receive the benefits otherwise available to them in tariffed or other publicly available rates without jeopardizing a rural health care provider's eligibility to receive the benefits of the rural health care support mechanism.

58. Because of the difficulties of allocating costs and preventing abuses, we also find that, in addition to telecommunications carriers, health care providers and consortia of health care providers must share in the responsibility for calculating and justifying the request for support by maintaining documentation of the amount of support for which each member of a consortium is eligible. Health care providers and consortia of health care providers must also carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the correct amounts. Accordingly, we revise section 54.601 of the Commission's rules to extend the record-keeping requirement to health care providers and consortia of health care providers. Finally, to the extent that a telecommunications carrier will not be applying the discount directly to a billing telephone number in the name of the rural health care provider, the rural health care provider and the lead member of the consortium must certify to the proper disposition of the benefits of the rural health

¹⁹¹ OAT and NTIA joint comments at 1.

¹⁹² *Id.*; see also OAT comments at 5.

¹⁹³ *Id.*

care support mechanism.

59. Based upon the information in the record, we also clarify that it is not necessary to set a time limit for rural health care providers to report the identities of all of the consortia participants in order to enforce the statutory prohibition against the resale of telecommunications services by rural health care providers, or to otherwise ensure that the support provided by the rural health care universal service support mechanism is used for the purposes intended by Congress. We find that USAC should permit a rural health care provider to add new consortium members by submitting a new form 465 that the Administrator will use to re-evaluate the eligibility of the rural health care provider. The rural health care provider must satisfy anew the competitive bidding requirements only if the addition of a new consortium member would be more than a minor change in the contract or other arrangement for service from the carrier.¹⁹⁴ Consistent with the *Fourth Reconsideration Order*, a rural health care provider must look to state or local procurement laws and regulations to determine whether a proposed contract modification would be considered minor, and, therefore, exempt from state or local competitive bid processes.¹⁹⁵ If a proposed modification would be exempt from state or local competitive bid requirements, the applicant would not be required to undertake an additional competitive bid process in connection with the applicant's request to add a new member to the consortium. Similarly, if a proposed modification would have to be re-bid under state or local competitive bid requirements, then the applicant would also be required to comply anew with the Commission's universal service competitive bid requirements in order to be eligible to receive the benefits of the rural health care program. Consistent with the *Fourth Reconsideration Order*, where state and local procurement laws and regulations are silent, or otherwise inapplicable with respect to whether a proposed contract modification must be re-bid under state or local competitive bid processes, the Commission will look to the "cardinal change doctrine" to determine whether the contract modification requires re-bidding.¹⁹⁶ The "cardinal change doctrine" generally examines the extent to which a modification exceeds the scope of the original contract.¹⁹⁷ We understand that USAC might prefer that rural health care providers list all possible participants in their initial applications, thus, permitting USAC to evaluate all participants at once. We, however, are not persuaded that the administrative difficulties are so great as to warrant restricting joint purchasing and network-sharing arrangements.

¹⁹⁴ See *Federal-State Joint Board on Universal Service, Access Charge Reform, Price Cap Performance Review for Local Exchange Carriers, Transport Rate Structure and Pricing, End User Common Line Charge*, Fourth Order on Reconsideration, CC Docket Nos. 96-45, 96-262, 94-1, 91-213, 95-72, 13 FCC Rcd 5318, 5448-5451 at paras. 223-30 (1997) (*Fourth Reconsideration Order*).

¹⁹⁵ *Id.* at 5450, para. 225.

¹⁹⁶ *Id.* at para. 226.

¹⁹⁷ *Id.* at 5449-5450, paras. 226-28.